Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TX 75034

Respondent Name
LEWISVILLE ISD

MFDR Tracking Number
M4-14-2583-01

Carrier's Austin Representative
Box Number: 19

MFDR Date Received
APRIL 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached the original claim with the original date that it was sent. Therefore, please kindly process with the consideration of it being timely filed PER RULE 133.20, as I have shown 'proof' of timely filing. ."

Amount in Dispute: $391.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The CMS-1500 form for the disputed dates of service was initially received on 8/7/13. Please see attachment 1, the 7/31/13 date of service was for CPT Code 97001-GP and there were no G-codes submitted at that time. Per rule 134.203 Medical Fee Guideline for Professional Services, which, with some exceptions, uses the most current reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid (CMS), including applicable payment policies relating to coding, billing, and reporting. Please see attachment 2, MLN Matter Number MM8166, Page 3, in which the Center for Medicare and Medicaid Services notifies physicians and other providers who submit claims for outpatient therapy services that beginning 7/1/13, claims that do not include the required functional reporting information will be returned or rejected. For this reason, this CS-1500 form for dates of service 7/17/13 and 7/31/13 was returned on 8/15/13. Please see attachment 3, the carrier returned the incomplete bill in accordance with rule 133.200. The same CMS-1500 form for the disputed dates of service was received via fax twic on 11/11/13 at different times. See attachments 4 & 5. Both bills were again returned on 11/12/13 as there were no G-codes provided. See attachments 6 & 7. The CMS-1500 form faxed and received by the carrier on 1/14/14 was complete, (see attachment 8) as it did contain the required G-codes and as such was processed on a Explanation of Benefits dated 1/30/14, ITN 00816541 (see attachment 9). Both dates of service were outside of the 95 day submission deadline and were denied with CARC 29 with audit notes… There has not been a reconsideration request after the 1/14/14 submission. The medical bill in dispute has not been correctly submitted for reconsideration. Reconsideration is required in this case prior to the request for MFDR…"

Response Submitted by: STARR COMPREHENSIVE SOLUTIONS, INC.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2013 July 31, 2013	CPT Code 99204-25 CPT Code 97001-GP	$391.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 29 – Per 133.20(b), except as provided in Labor Code 408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the service are provided.
   - This request is not a reconsideration bill as our records do not indicate a previous audit.

Issues

1. Is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, "except as provided in Texas Labor Code §408.0272(b)(c) and (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation submitted by the requestor finds no convincing documentation to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 16, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.